TITLE 114
LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 32
LONG-TERM CARE INSURANCE

§114-32-1. General.

1.1. Scope. -- The purpose of this rule is to implement W. Va. Code §33-15A-1 et seq., to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance.

Except as otherwise specifically provided, this rule applies to all long-term care insurance policies delivered or issued for delivery in this State on or after the effective date hereof, by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations.

1.2. Authority. -- W. Va. Code §§33-2-10 and 33-15A-6.

1.3. Filing Date. -- June 18, 1993

1.4. Effective Date. -- July 19, 1993

§114-32-2. Definitions.

For the purpose of this rule the terms "long-term care insurance," "group long-term care insurance," "commissioner," "applicant," "policy" and "certificate" shall have the meanings set forth in W. Va. Code §33-15A-4.

§114-32-3. Policy Definitions.

3.1. No long-term care insurance policy delivered or issued for delivery in this State shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

3.1.1. "Adult day care" means a program for six (6) or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

3.1.2. "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

3.1.3. "Home health care services" means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

3.1.4. "Medicare" shall be defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

3.1.5. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

3.1.6. "Personal care" means the provision of hands-on services to assist an individual with activities of daily living (such as bathing, eating, dressing, transferring and toileting).

3.1.7. Subject to the exception set forth in W. Va. Code §33-15A-6(c) for a policy or certificate issued to a group, "preexisting condition" shall not be defined more restrictively than "a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within six (6) months preceding the effective date of coverage of the insured person."

3.1.8. "Skilled nursing care," "intermediate care," "personal care," "home care," and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

3.1.9. All providers of services, including but not limited to "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," "personal care facility," and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

§114-32-4. Policy Practices and Provisions.

4.1. Renewability -- The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section 5 of this regulation.

4.1.1. No such policy issued to an individual shall contain renewal provisions other than "guaranteed renewable" or "noncancellable."

4.1.2. The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

4.1.3. The term "noncancellable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

4.2. Limitations and Exclusions. -- No policy may be delivered or issued for delivery in this State as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

4.2.1. Preexisting conditions or diseases;

4.2.2. Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's disease;

4.2.3. Alcoholism and drug addiction;

4.2.4. Illness, treatment or medical condition arising out of:

a. War or act of war (whether declared or undeclared);

b. Participation in a felony, riot or insurrection;

c. Service in the armed forces or units auxiliary thereto;

d. Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or

e. Aviation (this exclusion applies only to non-fare-paying passengers).

4.2.5. Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.

4.2.6. Section 4.2 is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

4.3. Extension of Benefits. -- Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

4.4. Continuation or Conversion.

4.4.1. Group long-term care insurance issued in this State on or after the effective date of this section shall provide covered individuals with a basis for continuation or conversion of coverage.

4.4.2. For the purposes of this section, "a basis for continuation of coverage" means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies which restrict provision of benefits and services to, or contain incentives to use certain providers and/or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The Commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

4.4.3. For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six (6) months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

4.4.4. For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers and/or facilities, the Commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

4.4.5. Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

4.4.6. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

4.4.7. Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

a. Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

b. The terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage:

A. Providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

B. The premium for which is calculated in a manner consistent with the requirements of Paragraph 4.4.6 of this section.

4.4.8. Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent (100%) of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

4.4.9. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

4.4.10. Notwithstanding any other provision of this section, any insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person, shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

4.4.11. For the purposes of this section, a "Managed-Care Plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

4.5. Discontinuance and Replacement. -- If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

4.5.1. Shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

4.5.2. Shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.

4.6. The premiums charged to an insured for long-term care insurance shall not increase due to either:

4.6.1. The increasing age of the insured at ages beyond sixty-five (65); or

4.6.2. The duration the insured has been covered under the policy.

§114-32-5. Required Disclosure Provisions.

5.1. Right to Return. -- A long-term care insurance policy or certificate shall have a notice prominently printed on the first page of the policy or certificate or attached thereto, stating in substance that the policyholder shall have the right to return the policy or certificate within the

time periods specified in Subsections 5.1.1 and 5.1.2, and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

5.1.1. For an individual or group long-term care insurance policy or certificate sold by direct solicitation or sold as a replacement policy or certificate, this notice shall state that the policyholder or certificateholder shall have the right to return the policy or certificate within thirty (30) days of its receipt.

5.1.2. For any other individual or group long-term care insurance policy or certificate not described in Subsection 5.1.1, this notice shall state that the policyholder or certificateholder shall have the right to return the policy or certificate within ten (10) days of its receipt.

5.2. Renewability. -- Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. This provision shall not apply to policies which do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

5.3. Riders and Endorsements. -- Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.

5.4. Payment of Benefits. -- A long-term care insurance policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

5.5. Limitations. -- If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."

5.6. Other Limitations or Conditions on Eligibility for Benefits. -- A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in W. Va. Code §33-15A-6(d) shall set forth a description of such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

5.7. Disclosure of Tax Consequences. -- With regard to life insurance policies which provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.

§114-32-6. Prohibition Against Post-Claims Underwriting.

6.1. All applications for long-term care insurance policies or certificates except those which are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

6.1.1. If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

6.1.2. If the medications listed in such application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

6.2. Except for policies or certificates which are guaranteed issue:

6.2.1. The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:

Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy.

6.2.2. The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address].

6.2.3. Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, the insurer shall obtain one of the following:

a. A report of a physical examination;

b. An assessment of functional capacity;

c. An attending physician's statement; or

d. Copies of medical records.

6.3. A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

6.4. Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily effectuated and shall annually furnish this information to the Insurance Commissioner in the format prescribed by the National Association of Insurance Commissioners in Appendix A.

§114-32-7. Minimum Standards for Home Health and Community Care Benefits in Long-Term Care Insurance Policies.

7.1. A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits:

7.1.1. By requiring that the insured/claimant would need care in a skilled nursing facility if home health care services were not provided;

7.1.2. By requiring that the insured/claimant first or simultaneously receive nursing and/or therapeutic services in a home, community or institutional setting before home health care services are covered;

7.1.3. By limiting eligible services to services provided by registered nurses or licensed practical nurses;

7.1.4. By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;

7.1.5. By excluding coverage for personal care services provided by a home health aide;

7.1.6. By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

7.1.7. By requiring that the insured/claimant have an acute condition before home health care services are covered;

7.1.8. By limiting benefits to services provided by Medicare-certified agencies or providers;

7.1.9. By excluding coverage for adult day care services.

7.2. A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

7.3. Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

§114-32-8. Requirement to Offer Inflation Protection.

8.1. No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

8.1.1. Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent (5%);

8.1.2. Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

8.1.3. Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

8.2. Where the policy is issued to a group, the required offer in Subsection 8.1 above shall be made to the group policyholder; except, if the policy is issued to a group defined in W. Va. Code §33-15A-4(e)(4) other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

8.3. The offer in Subsection 8.1 above shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

8.4. Insurers shall include the following information in or with the outline of coverage:

8.4.1. A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty (20) year period.

8.4.2. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

8.5. Inflation protection benefit increases under a policy which contains such benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

8.6. An offer of inflation protection which provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. Such offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

8.7. Inflation protection as provided in Subsection 8.1.1 of this section shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subsection.

8.8. The rejection shall be considered a part of the application and shall state:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection.

§114-32-9. Requirements for Application Forms and Replacement Coverage.

9.1. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing such questions may be used. With regard to a replacement policy issued to a group defined by W. Va. Code §33-15A-4(e)(1), the following questions may be modified only to the extent necessary to elicit information about health or long-

term care insurance policies other than the group policy being replaced; provided, however, that the certificateholder has been notified of the replacement.

9.1.1. Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?

9.1.2. Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months?

a. If so, with which company?

b. If that policy lapsed, when did it lapse?

9.1.3. Are you covered by Medicaid?

9.1.4. Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

9.2. Agents shall list any other health insurance policies they have sold to the applicant.

9.2.1. List policies sold which are still in force.

9.2.2. List policies sold in the past five (5) years which are no longer in force.

9.3. Solicitations Other than Direct Response. -- Upon determining that a sale will involve replacement, an insurer; other than an insurer using direct response solicitation methods, or its agent; shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One (1) copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner: (See Appendix B)

9.4. Direct Response Solicitations. -- Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner: (See Appendix C)

9.5. Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Such notice shall be made within five (5) working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

§114-32-10. Reporting Requirements.

10.1. Each insurer shall report to the Insurance Commissioner annually by June 30 for each agent that agent's total number of replacement sales, total number of policies sold and the total number of lapses of long-term care insurance policies sold annually by the agent.

10.2. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

10.3. Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.

10.4. Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.

10.5. For purposes of this section, "policy" shall mean only long-term care insurance and "report" means on a statewide basis.

§114-32-11. Licensing.

No agent is authorized to market, sell, solicit or otherwise contact any person for the purpose of marketing long-term care insurance unless the agent is licensed and appointed by the insurer to sell accident and sickness insurance in this state, prior to soliciting such insurance business.

§114-32-12. Discretionary Powers of Commissioner.

12.1. The Commissioner may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this regulation with respect to a specific long-term care insurance policy or certificate upon a written finding that:

12.1.1. The modification or suspension would be in the best interest of the insureds; and

12.1.2. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

a. The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or

b. The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

c. The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

§114-32-13. Reserve Standards.

13.1. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for such benefits shall be determined in accordance with W. Va. Code §33-7-9(3)(a)(A)(vii). Claim reserves must also be established in the case when such policy or rider is in claim status.

Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single

decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

13.1.1. Definition of insured events;

13.1.2. Covered long-term care facilities;

13.1.3. Existence of home convalescence care coverage;

13.1.4. Definition of facilities;

13.1.5. Existence or absence of barriers to eligibility;

13.1.6. Premium waiver provision;

13.1.7. Renewability;

13.1.8. Ability to raise premiums;

13.1.9. Marketing method;

13.1.10. Underwriting procedures;

13.1.11. Claims adjustment procedures;

13.1.12. Waiting period;

13.1.13. Maximum benefit;

13.1.14. Availability of eligible facilities;

13.1.15. Margins in claim costs;

13.1.16. Optional nature of benefit;

13.1.17. Delay in eligibility for benefit;

13.1.18. Inflation protection provisions; and

13.1.19. Guaranteed insurability option.

Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

13.2. When long-term care benefits are provided other than as in Subsection 13.1 above, reserves shall be determined in accordance with the provisions of Chapter 33, Article 7 of the West Virginia Code relating to accident and sickness insurance policies.

§114-32-14. Loss Ratio.

14.1. Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

14.1.1. Statistical credibility of incurred claims experience and earned premiums;

14.1.2. The period for which rates are computed to provide coverage;

14.1.3. Experienced and projected trends;

14.1.4. Concentration of experience within early policy duration;

14.1.5. Expected claim fluctuation;

14.1.6. Experience refunds, adjustments or dividends;

14.1.7. Renewability features;

14.1.8. All appropriate expense factors;

14.1.9. Interest;

14.1.10. Experimental nature of the coverage;

14.1.11. Policy reserves;

14.1.12. Mix of business by risk classification; and

14.1.13. Product features such as long elimination periods, high deductibles and high maximum limits.

§114-32-15. Filing Requirement.

Prior to an insurer or similar organization offering group long-term care insurance to a resident of this State pursuant to W. Va. Code §33-15A-5, it shall file with the Commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this State.

§114-32-16. Filing Requirements for Advertising.

16.1. Every insurer, health care service plan or other entity providing long-term care insurance or benefits in this State shall provide a copy of any long-term care insurance advertisement intended for use in this State whether through written, radio or television medium to the Commissioner for review or approval by the Commissioner to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer, health care service plan or other entity for at least three (3) years from the date the advertisement was first used.

16.2. The Commissioner may exempt from these requirements any advertising form or material when in the Commissioner's opinion, this requirement may not be reasonably applied.

§114-32-17. Standards for Marketing.

17.1. Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this State, directly or through its producers, shall:

17.1.1. Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

17.1.2. Establish marketing procedures to assure excessive insurance is not sold or issued.

17.1.3. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following:

"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

17.1.4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance.

17.1.5. Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this Subsection 17.1.

17.1.6. If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counselling program approved by the Commissioner, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificateholder that such a program is available and the name, address and telephone number of the program.

17.2. In addition to the practices prohibited in this State's Unfair Trade Practices Act [W. Va. Code §33-11-1 et seq.], the following acts and practices are prohibited:

17.2.1. Twisting. -- Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer.

17.2.2. High pressure tactics. -- Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

17.2.3. Cold lead advertising. -- Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

§114-32-18. Appropriateness of Recommended Purchase.

In recommending the purchase or replacement of any long-term care insurance policy or certificate, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

§114-32-19. Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates.

If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

114-32-20. Standard Format Outline of Coverage.

20.1. This section of the regulation implements, interprets and makes specific, the provisions of W. Va. Code §33-15A-6(g)(1)(A) in prescribing a standard format and the content of an outline of coverage.

20.1.1. The outline of coverage shall be a free-standing document, using no smaller than ten point type.

20.1.2. The outline of coverage shall contain no material of an advertising nature.

20.1.3. Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.

20.1.4. Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

20.1.5. Format for outline of coverage: (See Appendix D)

§114-32-21. Requirement to Deliver Shopper's Guide.

21.1. A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the Commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

21.1.1. In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.

21.1.2. In the case of direct response solicitation, the shopper's guide must be presented in conjunction with any application or enrollment form.

21.2. Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under W. Va. Code §33-15A-6.

§114-32-22. Penalties.

In addition to any other penalties provided by the laws of this State, any insurer and any agent found to have violated any requirement of this State relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

§114-32-23. Severability.

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

Appendix A

RESCISSION REPORTING FORM FOR
LONG-TERM CARE POLICIES
FOR THE STATE OF WEST VIRGINIA
FOR THE REPORTING YEAR 19[ ]

Company Name: _____

Address: _____

_____

Phone Number: _____

Due: March 1 annually

Instructions:

The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Date of Date/s

Policy Policy and Name of Policy Claim/s Date of

Form # Certificate # Insured Issuance Submitted Rescission

_____ _____ _____ _____ _____ _____

Detailed reason for rescission: _____

_____

_____

_____

_____

Signature

_____

Name and Title (please type)

_____

Date

Appendix B

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]: (Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary or waiting periods. The insurer will waive any time periods applicable

to preexisting conditions or probationary or waiting periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

_____

(Signature of Agent, Broker, or Other Representative)

[Typed Name and Address of Agent or Broker]

The above "Notice to Applicant" was delivered to me on:

_____

(Date)

_____

(Applicant's Signature)

Appendix C

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary or waiting periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary or waiting periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

_____

(Company Name)

Appendix D

[COMPANY NAME]

[ADDRESS--CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number] [Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers is incorrect, contact the company at this address: [insert address].

1. This policy is [an individual policy of insurance] ([a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]).

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [For an individual or group long-term care insurance policy sold by direct solicitation or sold as a replacement policy, insert the following language in boldface type:]

If you find that you are not satisfied with your policy, you may return it to [insert insurance company's name]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

[For any other individual or group long-term care insurance policy, insert the following language in boldface type:]

If you find that you are not satisfied with your policy, you may return it to [insert insurance company's name]. If you send the policy back to us within 10 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

5. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

6. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Non-institutional benefits, by skill level.]

[Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.]

7. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Non-eligible facilities/providers;

(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions/exceptions;

(e) Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in (6) above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

8. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time;

(b) Any automatic benefit adjustment provisions;

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time, if not by a specified amount or percentage;

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

9. TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.

[(a) Describe the policy renewability provisions;

(b) For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;

(c) Describe waiver of premium provisions or state that there are not such provisions;

(d) State whether or not the company has a right to change premium, and if such a right exists, describe clearly and concisely each circumstance under which premium may change.]

10. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

11. PREMIUM.

[(a) State the total annual premium for the policy;

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

12. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]